Issues to Consider When Working With Elderly Donors

Northwest Planned Giving Roundtable
September 16, 2016

Sam Friedenberg
Law Offices of Nay & Friedenberg
(503) 245-0894
www.naylaw.com
sam@naylaw.com
6500 SW Macadam Ave., Suite 300
Portland, OR 97239

Summary

1. The Importance of Legal Capacity
2. Planning for Health Care Incapacity
3. Planning for Financial Incapacity
4. High Conflict Personalities
5. Summary of Health Insurance Rules After ACA
6. Paying for Long Term Care Costs
7. Rules of Medicaid Eligibility
8. Medicaid Non-Eligibility Issues
9. Elder Abuse - Reporting
10. Elder Abuse – Legal Toolbox
11. Problems with the Elder Abuse Legal Toolbox

1. THE IMPORTANCE OF LEGAL CAPACITY (COMPETENCY)

A. The Problem. We all know the rules:

A person is PRESUMED to be competent. ORS 125.300(2). ORS 127.507. First Christian Church in Salem v. McReynolds, 194 Or. 68, 241 P.2d 135 (1952).

Incapacity is a LEGAL determination and can only be established by a court of law. ORS 125.005 et seq.

BUT people we meet do not appear competent! And how many folks go to COURT for a declaration of incapacity? Are these folks competent?

A good number of our citizens are in the gray area between capacity and incapacity, are capable for some things but incapable for others, or are perfectly capable but act as though they weren't. It matters because:

- Health care professionals we need to know when patients can consent to medical treatment.
- Legal professionals, we need to know when clients can direct, consent or execute documents.
- Other professionals need to know when individuals can direct and consent to plans and wishes.
- As family and friends, we need to know if we are dealing with a person who understands or does not understand the consequences of their actions.

CAPACITY is the threshold issue of so much involving the elderly or cognitively compromised.

B. Definitions. For help, we need to look at DEFINITIONS. Oregon has many and differing definitions of capacity and incapacity. All are limited by the imperfection of language and words. The best one can do is get a feeling of the *gestalt*. (Def. - an organized whole that is perceived as more than the sum of its parts – courtesy of Google.)

1. The best known legal dictionary defines 'capacity' as, the *Ability to understand the nature and effect of one's acts.* (Black's Dictionary of Law, Fifth Edition, 1979.)

2. Oregon has no statutory definition for capacity/competency/capability. Hence we spend our time defining capacity as "not incompetent". For the purpose of competency hearings in probate court:

> "Incapacitated" means a condition in which a person's ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person *presently lacks the capacity to meet the essential requirements for the person's physical health or safety*. "Meeting the essential requirements for physical health and safety" means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is likely to occur. ORS 125.005(5).

3. For the purposes of health care decision making, triggering the form of the Oregon Advance Directive:

> "Incapable" means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician, a principal *lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available*. "Capable" means not incapable. ORS 127.505(13).

C. Varies With the Task. ACTUALLY, the standard or definition for legal capacity also varies with the task to be undertaken or judged.

GENERALLY, irrevocable acts require more capacity than revocable acts. Hence, contracts, deeds and gifts require more capacity than wills, powers of attorney and trusts. Ryan v. Columbo, 77 Or App 71, 712 P2d139 (1985).

1. Contract. To agree in a contract, as to sell land, "Capacity includes the ability to reason and exercise judgment and, in essence, to bargain with the other party." First Christian Church v. McReynolds, 194 Or. at 73-4, 241 P.2d 135 (1952). The person must understand the nature and effect of the act. Kruse v. Coos Head Timber Co. 248 Or 294 (1967). This is applicable to the conveyance of property by deed but does not include Oregon's Transfer on Death Deed. A TODD requires the same capacity as a will. ORS 93.959(1).

2. Power of Attorney. No recent Oregon statute or case has stated a specific test of capacity for the signing of a financial power of attorney. In Wade v. Northrup, 70 Or. 569, 140 P 451 (1914), the Oregon Supreme Court stated that to sign a power of attorney the signor had to comprehend the nature of the business in which the signor was engaged. This appears to be a broad view that expects the signor to understand that he or she is signing a document delegating authority and not necessarily requiring an understanding of the acts which the agent might undertake under the document.

Also see ORS 127.002 *et seq*.

Where the document has been contested, some cases have reviewed the evidence and held on what appear to be equities of what specific acts the power of attorney undertook. See Hilt v. Bernstein, 75 Or. App 502, 707 P.2d 88 (1985). This judgment of the acts after the power of attorney has acted and from the perspective of whether the principal would have approved of the actual acts is noted in a law journal article: "Agency is a consensual relation; it is premised on the principal's ability to understand and either approve or disapprove of the agent's acts. When the principal lacks that ability, the agent should have no authority". Meiklejohn, Indiana Law Journal, Vol 61, No. 2 (1971).

3. Will. To make a will, "…(1) The person must be able to understand the nature of the act in which he is engaged; (2) know the nature and extent of his property; (3) know, without prompting, the claims, if any, of those who are, should or might be, the natural objects of his bounty,: and (4) be cognizant to the scope and reach of the provisions of the document." Kastner v. Husband, 231 Or. 133, 136, 372 P.2d 520, 522 (1962).

4. Trust. To establish, amend, revoke or fund a *revocable* trust, the person must have the same capacity necessary to make a will. ORS 130.500(1). The statute is silent on irrevocable trusts although analogy would suggest the capacity to execute a contract. ORS 130.820(1).

5. Gift. To make a gift one must have the capacity to contract. Kugel v. Pletz, 22 Or. App. 249 (1975).

6. Other. More statutes, cases and regulations can be found regarding deeds, changing life insurance beneficiaries, health care documents and other situations.

D. Measured at Point of Execution. It is very important to note that legal capacity is *measured at the point of execution of the document*. Uribe v. Olson, 42 Or. App. 647, 601 P.2d 818 (1979).

"Acting during a lucid interval can be a basis for executing a will…[A] person of pathologically unsound mind may possess testamentary capacity at any given time and lack it at all other times." Farnum v. Silvano, Mass. App Ct., No. 88-P-966, June 30, 1989.

E. Practical Matters. As a professional, here are some practical tips when addressing individuals with capacity issues.

1. Assessments.

a. Informal. The best assessment of capacity is through our own observation and interaction with the individual. Note:

- Appearance, greeting, gait (a symptom of dementia is difficulty with balance)
- Logical responses.
- Consistency in responses and desires.
- Living independently? Driving?
- Inquiries about ADLs.
- The ability to articulate 'why' in complex terms.
- Apparent influence by others.

b. Formal. There are many tests for incapacity but no "industry standard." Each professional must use his or her best professional judgment for the determination. This author uses a combination of methods including the Mini-Mental State Examination (variations but usually 10 - 12 questions, 30 points), questioning around the will standard and questions related to finance, e.g., what is a credit card? A deed? A share of stock?

c. Is Administering a Test Appropriate? Note that there are some professionals who shy away from formal tests under the logic that they are not trained to administer them or interpret the result. The fear is that this lack of certification for the test could be used against the professional. While there is some logic to this position it must be balanced with the need to undertake due diligence in our work and the fact that not every case warrants a costly and time consuming professional assessment.

2. Consequence of the Act. Every act undertaken with a person with diminished capacity has the possibility of being contested. This is particularly true of irreversible acts like gifts. Hence the professional must take into account the consequence of the act: whether the act is neutral or a forfeiture of legal rights, whether it favors close family and friends or a newcomer, whether legal counsel was sought, avoided or irrelevant, etc. For example:

- A power of attorney naming an adult child versus a neighbor.
- A gift to a new charity versus one with a pattern of donations.
- A will naming recent friends versus established relatives.

F. Resource. A fabulous resource is Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers (ABA Commission on Law and Aging and American Psychological Association (2005). Some issues addressed:

- Differences between clinical, diminished, decisional and legal capacity.
- Different tests.
- Whether or not tests should be given.
- Maximizing capacity.

G. Summary. Capacity is a fulcrum for tasks and planners. If an individual has it, ok. If one doesn't, stop. Mostly the issue arises when capacity is in the gray area. Most professionals now agree that there is a sliding scale of capacity. This means it varies based on the day, time of day, task, consequence and more. Don't assume it does not exist. Only low levels of capacity may be necessary for many tasks.

2. PLANNING FOR HEALTH CARE INCAPACITY

That is, how do issues of health care, placement and end-of-life decisions get made during a person's mental incapacity? What can be done to make decision-making simpler?

A. No Pre-Planning. Many people have not done advance planning for health care decisions. Society keeps on working based on defaults.

1. Emergency Treatment. Emergency treatment does not require prior informed authorization or consent.

2. Developmentally Disabled Individuals. The Department of Human Services of Oregon has the custody and care of some individuals with developmental disabilities. OAR

309-041-1300 *et seq*. Their health care decisions, placement, etc., are managed by an Individual Support Plan Team (ISP team) and it frequently acts as a surrogate decision maker if there is no court appointed guardian. OAR 309-041-1350

3. Kinship or "Family Consent".

a. Principle. There is a common law principle that if consent is necessary, and a close relative of the patient gives consent, it usually controls and goes unchallenged. The principal evolved regarding the consent of a parent to his/her minor child's medical treatment.

b. Oregon. This is how most of society functions but it is a gray area of law in Oregon because, except for end of life situations, there is no express authority for it among adults. As a practical matter, the medical environment in Oregon has been supportive of individual and family wishes even when formal documents are not in place. Yes, a medical provider can be liable for medical treatment given without consent, but this is not a common area of liability.

c. Washington. Washington has a statute expressly allowing family consent.. See RCW 7.70.065:

> (1) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(e), to consent may be obtained from a person authorized to consent on behalf of such patient.
>
> (a) Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, based upon a reason other than incapacity as defined in RCW 11.88.010(1)(d), shall be a member of one of the following classes of persons in the following order of priority:
>
> (i) The appointed guardian of the patient, if any;
>
> (ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
>
> (iii) The patient's spouse or state registered domestic partner;
>
> (iv) Children of the patient who are at least eighteen years of age;
>
> (v) Parents of the patient; and
>
> (vi) Adult brothers and sisters of the patient.

4.Evidence of a Person's Wishes. On the issue of life support, all evidence of a person's wishes is relevant. This includes a formal document that is improperly executed.

5. End of Life: Statutory Priority. In the absence of contrary intent, the Oregon statutes authorize people to act as health care representatives to address **life-sustaining procedures** (not other health care issue). The patient must be found to have a terminal condition, or be permanently unconscious, or be in a "condition in which administration of life-sustaining procedures would not benefit the principal's mental condition and would cause permanent and severe pain," or be in a very advanced and fatal dementia. The order of priority is: a guardian (if any), spouse, "an adult designated by the others listed in this subsection" if no one objects, a majority of adult children, either parent, a majority of adult siblings and "any adult relative or adult friend." ORS 127.635

a. Surprisingly, "[i]f none of the persons described. . .[above] is available, then life-sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending physician." ORS 127.635 (3).

b. All people acting under this statute must consult with "concerned family and close friends, and if the principal has a case manager, as defined by rules adopted by the Department of Human Resources, after giving notice to the principal's case manager." ORS 127.635 (4).

c. Relying on this statute may be a problem because the provider and physician may worry about their liability.

6. Life Support – Statutory Presumption. Oregon has a statutory presumption that every person who is incapacitated has consented to artificially administered nutrition and hydration that is necessary to sustain life. ORS 127.580 (1). This presumption was diluted in the 1993 legislature by adding a series of exceptions that include a broad view of the person's statements, the instructions of those people with authority to make the decision and specific facts where life support is unlikely to be wanted. In this author's opinion, the statutory presumption is no longer significant.

7. Sympathetic Medical Environment. As a practical matter, the medical environment in Oregon has been supportive of individual and family wishes even when formal documents are not in place. Consequently, a problem with one provider can often by addressed by changing providers.

B. Considerations in Naming a Health Care Decision Maker.

1.Goals. From the point of view of an individual who may be incapacitated in the future, he/she will want to have a say in decisions concerning their healthcare. The issue may be a simple one, such as access to the individual's medical records. The issue may be a significant one, such as where the individual will live or whether or not his/her life will be extended by life support systems. From the point of view of the family, any expression of intent is helpful because it will lessen the agonizing over the issues.

2.Legal Capacity. The importance of legal capacity is arguably greater with these civil right issues than with financial issues. As was mentioned, documents must be signed with legal capacity.

3.Choosing the Proper Person. Choosing the proper health care decision maker is critical because of the personal nature of the decisions. The person chosen is often different from the named financial fiduciary. There is no need for consistency between fiduciaries for finances and health care.

4.Physician or Provider Liability. On end-of-life issues, the liability of the physician or provider is often an issue. Oregon forms, in contrast with generic forms, are accompanied with statutory provisions that generally shield these people from liability. To this end, they are preferred.

C. Medium Formality Methods. These methods, consisting of signing documents, are often undertaken without a lawyer but generally are part of estate planning with a lawyer.

1. Advance Directive for Healthcare (ADHC). This is the last (1993) and best form penned by the Oregon legislature. As with the POAFHC, the document allows the signer to: (a) name an agent (called a healthcare representative) to make a variety of healthcare decisions, and (b) state whether he/she wants tube feeding or other life support in a variety of factual situations. The form specifically addresses a terminal illness, an advanced progressive dementia, a coma or persistent vegetative state and a condition where life support would cause great pain.

a. The ADHC eliminates the seven-year expiration by allowing the signer to elect validity for life.

b. The ADHC allows the signer to make room for special circumstances. One recommended addition is authority to give a do not resuscitate order. Another possibility is naming someone the signer does not want as his/her healthcare representative.

c. The chief disadvantage of the ADHC is that it is long, cumbersome to complete and difficult for many to understand.

d. One characteristic is that if the signer is in a nursing home or long-term care facility, one of the witnesses needs to be from the State Ombudsman's office. This is not true of a POAFHC.

2. Declaration for Mental Health Treatment. In 1993, the Oregon legislature created a document allowing someone to nominate an agent for mental health treatment and for the purpose of being involuntarily committed for up to seventeen (17) days. ORS 127.700 et seq. It is contingent on a diagnosed mental disorder and includes options for psychoactive medications and convulsive treatment. A court or two physicians must document that the individual lacks capacity. The document is valid for three years.

a. A problem with the document is that medical providers will usually not come forth and declare a person incapacitated without a court guardianship or civil commitment. In other words, it does not generally circumvent court involvement.

b. A guardianship may be the better solution in cases where mental health problems continue without progress in behavior modification.

c. A provider may only act contrary to the declaration if the individual has been involuntarily committed or is in a life-threatening emergency.

3. Physician Orders for Life Sustaining Treatment (POLST). This form, with its bright pink hue, is less of an advanced directive and more of an order for a specific treatment during a specific period of treatment. It is to be signed by the physician after consultation with the patient

and/or the surrogate decision maker. (It may also be signed by the patient as an option.) It is meant as an instruction in an actual or near acute situation. This is in contrast with an advanced directive signed by a person in advance of a period of incapacity. The POLST form does not name a health care decision maker.

4. Other Forms. These forms have, in practice not law, superseded earlier forms such as the Advanced Directive and the Power of Attorney for Health Care.

D. Formal: Guardianship. This is a court-supervised procedure for establishing a healthcare decision-maker. ORS 125.005 et seq. It is usually sought when a person is incapacitated and there is a problem requiring a surrogate decision maker. It is begun with a lawyer.

1. Legal Definition of Incapacity. The level of incapacity necessary for a guardianship is set forth in the law. There are statutory definitions and there is case law, but there is still always room for argument. *The following approach is helpful: The person must have (a) a condition or impairment that affects their ability to receive and evaluate information or to communicate decisions; (b) the condition prevents them from providing for basic personal needs; (c) the inability to provide for those needs is such that serious harm will likely result to them (not necessarily to another); and (d) the appointment is necessary to provide continuing care and supervision.* Unfortunately, case law seems to be raising the standard. The case of In re Roger Schaefer (2002) suggests that "serious harm" has been replaced with "life-threatening." It is unclear whether this trend will continue or be reversed.

2. Procedure. As with a conservatorship, the procedure is begun with a petition to the court. However, in addition of the formally served notice and the 15 day notice period, the protected person is given the protection of an investigation by a "court visitor" to evaluate the allegations of the petition. There is a court appearance only if there is an objection. There is no right to legal counsel. Once appointed, a guardian has all the obligations analogous to a parent over a minor child. There is an annual report that must be filed with the court.

3. Appropriateness. This procedure is undertaken if no less formal means of healthcare management will work. It is also recommended if there is a high probability of a problem in the future.

4. Cost. Absent an objection, the costs of a guardianship are not significant because there is no bond, inventory or annual accounting. The annual report is a simple one.

5. Limitations. A guardian must be aware that being in the role will not necessarily solve his/her problems. For example, a guardian may not be able to control an individual's aggressive behavior, an individual's desire to avoid placement, regular medications or promiscuous behavior. This is a greater problem with mental health problems than with dementia symptoms.

a. The guardian has statutory limitations such as authorizing psychotherapy treatment and sterilization (for sterilization, see ORS 436.205 et seq.).

b. There are also fundamental (perhaps, constitutional) limitations such as the right to freely associate, vote and privacy.

6. Emergency. There are provisions for establishing a guardianship in an emergency. The statute requires an "immediate and serious danger to the life or health of the individual." ORS 125.600 (1). The courts have, in general, interpreted this requirement broadly.

7. Trend. Due process rights of individuals are increasing and the result will be (i) a greater number of objections, and (ii) fewer filings.

E. Highest Level of Formality: Involuntary Civil Commitment. A court procedure in which the state, not the family or loved ones, initiates a process to involuntarily commit a person to a mental health facility because the individual is (a) a danger to his/herself or others, or (b) unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety, or (3) mentally ill, has been committed twice in three years and is exhibiting similar symptoms. ORS 426.005 et seq. There is a five day period, known as the "hold", during which treatment is given and at the end which an investigation occurs to determine the need for a hearing and further commitment. If the person is still dangerous after five days, there must be a

hearing. If the result of the hearing is the need for continued commitment, then the state can hold the person for up to 6 months without further hearing.

1. As a practical matter, the state bends over backwards to release individuals within the five day "hold." This is due to the cost of holding and treating persons.

2. The state will attempt to bill the individual treated beyond the five day hold. The cost is extraordinary.

F. Recommended Plan. Everyone should have an Advanced Directive for Healthcare naming a healthcare decision-maker and stating intent on end-of-life decisions. Discussions about end of life should be consciously made and memorialized. If issues of placement or health care are continuous and serious, a guardian should be appointed.

3. PLANNING FOR FINANCIAL INCAPACITY

That is, how do the finances of a person get managed if he/she becomes incapacitated? How can we make this simpler?

A. Considerations in Choosing Legal Tools for Financial Management.

1.Goals. From the point of view of the individual who might be impaired, the goal is to pick the best substitute decision maker and have him/her act consistently with the impaired's wishes. From the point of view of the family, the goal is to have the legal tools to make the financial decisions that the impaired person will need during his/her incapacity. Other goals are, generally, minimizing administrative expenses, simplicity, not interfering with an existing estate plan and eliminating negative tax consequences.

2.Conflict. Needless to say, the above goals may conflict. In particular, the family may want simplicity and low cost while the impaired may be unwilling to cooperate in the most informal plans.

3. Legal Capacity of Impaired. Legal documents must be signed with legal capacity.

a. Note that the necessary legal capacity is a relative state to be measured at the point of execution and depends on the complexity of the document and the nature of the transaction, among other things. Different attorneys have different approaches.

b. Determining that capacity exists for a document and then filing for a guardianship for the individual are inconsistent. The court declaration of incapacity in the guardianship will color, and arguably invalidate, the signed document.

4. Safety of Impaired. If there is a probability of abuse of the impaired, the most formal approach, a conservatorship, is best.

5. Cooperation of Impaired. Most tools are revocable and valuable only to the extent that the impaired person cooperates. A revocation, however, requires capacity.

6. Fiduciary Duty. A fiduciary is a person having a duty to another and is used generally to describe the decision-maker for the impaired regardless of the tool used in creating that duty. The duty is very high and, though it is beyond the scope of the topic here, should be considered in establishing the fiduciary.

B. Spectrum of Options. It is best to consider the planning options on a spectrum of formality, from the most informal to the most formal. Generally, the family that **plans in advance** can solve its problems with the most informal options.

C. Informal Methods. There are tools for managing finances with little or no involvement from attorneys, courts or other professionals.

1.Joint Accounts. The second "owner" (or "joint" owner) can deposit funds, make withdrawals, write checks, receive statements and otherwise manage the account.

a.Problem / Risk. The problem is that this type of account can lead to: (i) misappropriation of funds, (ii) receipt of funds on the impaired person's demise contrary to the will or intent of the impaired, (iii) loss of tax advantages such as step-up in basis of assets with capital gains, and (iv) may make assets subject to the legal problem of the

added "owner" (divorce, creditors, lawsuit and bankruptcy). Each family weighs the simplicity of joint-ownership with its risks.

b.Balance. The risk of joint ownership must be balanced with the effectiveness and convenience of the method. This author believes that joint ownership is appropriate for checking accounts. It should not be used for other types of assets, especially real property and automobiles, and cannot be used for some assets, such as IRAs and pension plans.

2.Income – Representative Payee. The Social Security Administration and some pension sources have a procedure to pay monthly income to a "representative payee" for the benefit of the retiree. Application is made through the agency or pension source and, at least with Social Security, does not require the active participation or consent of the retiree.

3.Electronic Deposits. Can be of a pension or investment income. Can prevent checks from being misplaced.

4.Electronic Payments. Particularly useful for health and long-term care insurance that should not lapse for lack of payment.

D. Medium Formality Methods. These methods are generally done with the assistance of an attorney but need no court involvement.

1.Power of Attorney for Finances. A legal document that gives one or more people the authority to act for, and in the place of, the person who is creating the power of attorney. It creates the legal relationship of principal and agent. The person creating the power does not lose any rights and the agent does not gain the power to take away rights. Single most common estate planning approach.

a. The authority given can be limited or broad. For most people, it should be broad ("general") to allow the fiduciary to undertake all possible transactions.
b. Some unusually broad powers, often recommended for people with Alzheimer's or persons requiring expensive long term care, include language

allowing gifts, transfers from the principal to the agent, the establishment and funding of trusts and change of beneficiaries.

c. It can only be created by a person with legal capacity to understand his/her actions.

d. The greatest disadvantage is that financial entities (banks, brokerage houses, federal government, insurance companies, etc.) need not accept the document. In most instances, however, they do.

e. Best avoid the 'springing power of attorney' that goes into effect on a future event. ORS 127.005(2).

2.Revocable Living Trust. Is also known as a probate-avoidance trust. Is a private agreement (contract) between an individual and a trustee (first usually the same person and then a family member) that the trustee will manage the person's assets for his/her benefit during a period of incapacity. It will also serve as a will-substitute on the demise of the beneficiary. This last characteristic is, in the author's opinion, what makes the tool so popular.

a. Revocability allows the grantor to change his/her mind.

b. Has to be created by person with legal capacity or with power of attorney specifically authorizing it.

c. Some assets, by definition, cannot be placed in trust, thereby requiring a power of attorney. Examples are IRAs and pension plans.

d. More commonly accepted than powers of attorney.

E. Highest Formality: Conservatorship. A conservator is a court-supervised financial manager and is usually a family member. The procedure is initiated after an individual has lost the ability to handle finances. It requires a petition to the court, personal service on the protected person, a formally served notice and a 15-day notice period for the impaired to object. Only if there is an objection will there be a court-appearance. Once appointed, the conservator must file a bond in the amount of the assets, an inventory of assets and each year must account for every cent of the conservatorship. Additionally, the conservator must receive court permission to sell the impaired's primary residence and to undertake certain other acts.

1. This procedure is the most protective and most appropriate if (i) no less formal means of managing assets are in place at the time of incapacity, or (ii) there is concern about the impaired person being the subject of financial abuse, or (iii) there is a dispute as to who is the most appropriate person to handle the finances.

2. Due to the court supervision, it is the most expensive tool. The author finds that clients, once apprised of the work and costs, are usually reluctant to undertake this approach.

3. A disadvantage is that, in some instances, the court will not allow a conservator to plan for governmental benefits. This problem would not exist if the person with Alzheimer's still retained capacity, or had executed an effective power of attorney or trust. Note that Multnomah County Circuit Court, where there has been the greatest problem, is relaxing its position in some instances.

F. Recommended Plan. Each individual and family will have a different method to address financial incapacity. For example, thorough planning for a person owning real estate would include the revocable living trust. In all events a person should have a financial power of attorney.

4. HIGH CONFLICT PERSONALITIES

Any individual interacting with the public will ultimately learn of the relatively large number of high conflict personalities (HCP). When the individual is a professional and the subject is family, money, heritage, legacy, law, and taxes, the probability of conflict increases. It is invaluable to navigate high conflict people and this is a very brief primer. It is largely based on the work of a lawyer/therapist, Bill Eddy, and his works, including High Conflict People (High Conflict Institute Press (2012).

A. The Problem. High conflict personalities are frequently people with personality disorders and, if clinically diagnosed, can be described in the Diagnostics Systems Manual of the American Psychiatric Association. They have enduring patterns of self-destructive interactions, persistently blame others, have no insight or acceptance of their own role and are unable to change.

According to NIH (2001-5), the prevalence in our culture varies from 1.8% to 6.2% of the population. Their prevalence in the legal system has not been estimated (except for Antisocial Personality in the criminal system). Personality disorders are considered untreatable but that conclusion is being challenged. There are no medications specifically for these conditions.

B. Types. The five most prevalent personality disorders and characteristics are:

1. Narcissistic. Absorbed in self, own needs and views, wanting special treatment and missing empathy.

2. Borderline. Instability in mood, behavior and self-image. Swings from exaggerated affection to extreme dislike or need for revenge. ("Good book, bad book")

3. Paranoid. Irrational fear and doubt about others, misinterpretation of actions, conspiratorial and holds grudges.

4. Antisocial (aka 'Sociopath'). Disregard of rules and laws, need to be superior, missing empathy, lying and need to dominate.

5. Histrionic. Need to be center of attention, dramatic, exaggerates, and commonly likes being a victim.

These are not hard and fast categories; there is over lap among them and among other mental health disorders.

C. Coping Strategies. As a professional, HCPs will play a significant role in your life. They are frequently intelligent, charming and adept at making others feel needed. You need to understand and address HCPs. Bill Eddy has a wealth of coping strategies, including:

A. Being Special. Be aware that the HCP will make the professional feel special. They will demonstrate how much they trust him/her and can confide with him/her. They will show an exaggerated sense that the professional will solve the problem and protect them. All this is unrealistic and is likely to fall apart. Then the HCP will be disappointed and professional will be blamed.

1. Manage expectations; set limits.

2. Do not give priority or special treatment.

B. Boundaries. The HCP may try to blur the boundary between the personal and the professional.

1. Maintain clear boundaries.

2. Maintain ethical boundaries.

C. Truth. HCPs will exaggerate and misrepresent the truth due to their inability to square their world with reality.

1. Avoid believing your client too much.

2. Make your responses conditional, e.g., 'lets check on that.'

D. Best Practices. Do not let the HCP's 'disability' negatively impact your best practices.

1. Calm things.

2. Show appropriate empathy.

3. Acknowledge when the HCP is upset.

4. Be attentive.

5. Be respectful.

6. Assist with organization.

5. SUMMARY OF HEALTH INSURANCE RULES AFTER ACA

A. The Affordable Care Act (ACA). The ACA, which includes the Health Care and Education Reconciliation Act of 2010, is the greatest change to the health insurance landscape since the establishment of Medicare in 1965. It is legislation too broad to summarize and includes the regulation and rationalization of the practice of medicine, expanded health insurance coverage, tax incentives, and experiments in health care practice.

B. Mostly Unchanged. Essential to the politics of the ACA is the fact that most persons have no change to their health insurance coverage other than increased benefits. These include the

prohibition for disqualification for prior conditions and the inclusion of adult children to age 26 in the parents' coverage. The unchanged landscape includes:

1. Medicare. Medicare is health insurance for persons over 65 and certain disabled persons.

2. Medicaid (Medical Assistance). Medicaid provides health insurance coverage for certain low income and needy people. It is a basic medical insurance program and in Oregon is generally through the Oregon Health Plan (OHP).

3. Private Health Insurance. The traditional employer-provided or privately purchased health insurance is also largely unchanged.

C. The New Landscape. While the majority of programs have not changed, the medical insurance landscape has changed and this has affected a lot of people. Rather than just list the changes, below is a list of the types of coverage that exists for the vast majority of Oregonians.

1. Under 65. As noted, an insured with a traditional plan will not have any significant changes to that plan. However, if a person is uninsured, there is a mandate for coverage. Most persons who do not have health insurance coverage must either purchase it through an ACA-established exchange or pay a penalty. Each state has a health insurance market place which acts as a coordinating point for the purchase of health insurance. Exceptions to coverage include very low income working persons, certain ministers, certain Native Americans, and others. See https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/

2. Under 65 – COBRA. COBRA health insurance coverage applies to persons who have lost their employer coverage due to a "qualifying event" such as dismissal. It includes spouses, children, former spouses and dependents. They must actively elect continued coverage for as much as an additional 18 months (and in some plans 36 months). Premiums will likely be a bit higher than those existing through employment.

3. Minor or Pregnant. An individual who is a minor (under 18) or pregnant can qualify for health insurance under Oregon Health Plan (OHP) subprograms. These are Medicaid programs. Subprograms include OHP Healthy Kids and CHIP for minors and OHP Plus

Supplemental for pregnant adults over 21. Rules of eligibility rely on income and are calculated under the Magi Medicaid income eligibility standards, below. However, a pregnant woman can have up to 185% of the income poverty line and children can be covered if household income is less than 300% of the income poverty line.

4. Under 65 & Disabled - SSD & Medicare. A person who is under 65 and disabled with Social Security Disability income can get Medicare health insurance. Some disabilities must be proven and some, like end stage renal failure and ALS, create categorical eligibility. Most disabled persons must wait 24 months from the date the disability began. The exception is for the categorical eligibility conditions. Medicare is a basic 80% policy with two parts. Part A covers hospitals and doctors and is free, and Part B covers many other services for a monthly premium of $105.50 (2015) deducted from the individual's Social Security check. Additionally, prescription coverage can be purchased through Part D programs. Providers can be the traditional fee-for-service provider or managed care providers. To the extent that there are gaps in coverage, high premiums or unaffordable co pays, Medicaid programs can help.

5. Under 65 & Disabled – Low Income. For a person under 65, disabled, impoverished, with low income and particularly if they are on Social Security Supplementary Income (SSI) that has a cap of $733 per month (2015), health insurance is available through the Oregon Health Plan. (There is no longer a distinction between OHP Standard and OHP Plus; there is only OHP Plus.) There are very complex rules of eligibility that include income and resources, however, most coverage here has been shifted to the MAGI Medicaid rules below. Coverage is through contracted Coordinated Care Organizations. Application must be made every 12 months and there is no limited enrollment period. Again, additional programs are available to assist with co-payments and deductibles. One common program is the Qualified Medicare Beneficiary (QMB) benefit that pays Medicare premiums, etc.

6. Under 65 & Low Income – 'MAGI Medicaid'. Some states, including Oregon, expanded Medicaid/OHP to include low income but not completely impoverished persons. This coverage has more liberal income eligibility standards and is referred to as 'MAGI Medicaid'. The typical eligibility is for persons with income that is less than 133% of the poverty line (with a

5% income disregard). However the rules are, again, complex. There is no resource limit for eligibility. MAGI Medicaid does not apply if there is other coverage, for example, if the person is pregnant, is on Medicare or has other health insurance. It is basically an OHP Plus package. One interesting additional benefit is up to 30 days of long term care services.

7. Over 65 - Supplemental Social Security Income (SSI). For a person over 65, whether or not he or she is disabled, impoverished and with income of less than $733 per month (2015), health insurance is available through Medicare and certain state supplements such as OHP with Limited Drug benefits for dual Medicaid/Medicare Part D coverage.

6. PLANNING FOR LONG-TERM CARE COSTS

Among the most significant gaps with the ACA and health insurance is long-term care. That is, assistance with the activities of daily living and companionship by persons other than doctors and nurses. What can be done if one cannot afford the cost of long term care?

A.Private Insurance. Perhaps the best means to meet nursing home or other long-term care costs is a form of health insurance known as nursing home insurance or long-term care insurance. Since 1989 Oregon has statutorily required thorough coverage. These policies pay for all levels of nursing home care without requiring a three day hospital stay within a month of entering the nursing home. They also make payments for adult foster care, in-home care, and for care received in a residential care facility.

The cost of such policies depends on the age of the individual at the time of purchase, the daily benefit amount that would be paid out (can range from $10 to $200 dollars per day), the waiting period in which the nursing home patient pays the daily nursing home charge and, finally, the number of years the policy will continue to make the daily benefit after the waiting period. Be aware that benefits payments may be paid out for as short as one year or as long as the individual's remaining lifetime. The variance in benefit duration is an important factor to consider. Unfortunately, the cost of these policies is beyond the reach of many working class

Oregonians. Additionally, many individuals cannot qualify for this kind of insurance as a result of their existing health conditions. Currently approximately 2 per cent of all long term care dollars come from long term care insurance.

B. Veteran's Benefits. Benefits from the Federal Veteran's Administration changed greatly during the early 1990s. Direct care through VA hospitals, outpatient clinics, nursing homes and domiciliaries was substantially cut back. As a result of these changes, direct care eligibility is now based upon the income and assets of the veteran and spouse for all but service-connected disabled veterans. Virtually all community nursing home contracts have been eliminated or reduced.

The most common benefit available to veterans requiring long-term care as a result of a non-service connected disability is an Aid and Attendance Pension. It is a monthly cash benefit often exceeding $1,000 per month. Although both the veteran and spouse's income and assets (excluding family home) are considered in granting this important benefit, substantive monthly care costs can offset the combined income and assets of the couple to yield a substantial monthly award. Currently approximately 2 per cent of long term care dollars is paid by the Veterans Administration.

C .Medicare. Medicare is a federal health insurance program for people aged 65 years and above, people of any age with permanent kidney failure and people who have received Social Security disability benefits for two years or more. Unfortunately, the program provides limited long-term care benefits.

1.Medical Insurance: Parts A and B. Medicare was created to cover traditional doctor and hospital expenses, not long term care. It has two parts.

a.Part A covers hospital inpatient, follow up and limited institutional care such as skilled nursing facilities (detailed below), home health and hospice.

Part A is financed through the Social Security tax. Most Part A benefits are subject to deductibles and/or co-payments, with annual price changes.

b.Part B covers physician charges and other medical services in an office or your home, outpatient speech and physical therapy charges, physician directed in-home care requiring skilled nursing care or skilled therapy (BUT NOT 24-hour nursing care at home), medical equipment to be used at home and other services. Participation in Part B is voluntary and is financed by monthly premiums paid by enrollees by automatic deduction from Social Security and Railroad Retirement checks and general federal revenues.

2. Medicare Long-term Care Benefits. The federal Medicare program does reimburse a limited amount of long-term care services. For an excellent summary of complete Medicare benefits, Medicare booklets are available at your nearest Social Security Administration office or by contacting ACP-ASIM (The American College of Physicians and the American Society of Internal Medicine merged into this new organization) at 2011 Pennsylvania Avenue, N.W., Suite 800, Washington D.C. 20006-1808, (202) 835-2746.

a. 100 Days of Skilled Nursing Home Care. Skilled nursing care is only provided upon the physician's certification that the patient needs skilled nursing care or skilled rehabilitation services on a substantially daily basis and those services can only be provided in a nursing facility. In addition, the patient must enter the skilled nursing home within 30 days following a hospital stay of three days or more. Medicare pays 100% of the first twenty days. Medicare will help pay for days 21 through 100 in a skilled nursing facility, however, the patient is responsible for a significant daily co-payment.

b. If the patient enters skilled nursing care from home, Medicare will not pay. Fortunately, only 2% to 3% of all nursing home patients ever require skilled nursing care.

c. Skilled nursing or rehabilitative care is terminated if the patient stops making noticeable improvement as a result of the nursing or rehabilitation. This results in the patient being "decertified" out of skilled care, down to intermediate care, meaning private

pay begins. Skilled nursing care or rehabilitation services are those that require technical or professional knowledge or experience.

d.Hospice. Hospice care designed to comfort the dying rather than to seek a cure or remission of the condition. It is 'palliative.' To qualify for hospice care, the patient must be certified to be terminally ill, meaning a prognosis of no more than six months to live. The patient must also acknowledge that the purpose of the care is not cure or remission and waive Medicare payment for other services for treatment of the condition.

e.Home Health Care. Home health care is physical, occupational or speech therapy, nursing, medical social services, part-time or intermittent home health aide service, and non-drug medical supplies furnished in the home on a visiting basis. To qualify for home health care, the beneficiary must (a) be under a doctor's care and (b) need the service. The services provided are by a home health agency, following a doctor's plan.

f.Medicare Pays Approximately 2% of Long Term Care Costs. Even though Medicare was to be the major health care reimbursement program for people over 65 years of age, long-term care was not comprehensively included in the program. As a result, Medicare paid less than 2% of the nation's total nursing home costs.

D. Medicaid. Medicaid is a joint federal/state program that pays for long term care in foster homes, nursing homes, assisted living facilities, residential care facilities and even in the home. The rules of eligibility form part of the Social Security Act. Medicaid eligibility is based on assets and income and, in Oregon since early 2003, the level of disability of the individual. The rules also vary depending on the placement setting.

1. Medicaid Pays Approximately 50% of Nursing Home Costs. Medicaid pays a portion of the cost of long term care for approximately 66 percent of the long term care population in the USA, approximately 60 percent of Oregonians in long term care, for a total of approximately 50 percent of all long term dollars spent. This is the greatest proportion of nursing home payments. Because Medicaid patients must contribute some or all of their income toward care, and some

patients can afford to pay privately, private funds account for approximately 46 per cent of the total long term care bill.

2. Volume Buying. Because of Medicaid's position in the market, it pays a lower reimbursement rate to the provider than what the provider would charge privately. In Oregon the rate is approximately 71 % of the private pay rate. This difference means that not all facilities will accept Medicaid. Given the expensive cost of care, however, the vast majority of facilities do accept Medicaid.

3. Medicaid Treatment is Equitable. It is a matter of law that a facility cannot treat a Medicaid patient differently than a private pay patient. Studies in Oregon made by gerontologists and the Alzheimer's Association unequivocally support this principle. Two exceptions exist with regard to Assisted Living Facilities and Residential Care Facilities: (1) these can ask a patient to share a room and (2) they can ask that the patient pay privately first for some period of time as a condition of admission.

4. Exclusive Source. It is important to note that if a person is granted Medicaid eligibility, the provider can not charge the family for the difference between the private pay rate and the Medicaid rate. The facility would be committing a crime. The only way a provider can receive additional reimbursement from the family is if the family wishes to pay extra for services Medicaid does not provide (such as a television, telephone and other such amenities).

5. The Middle Class is Vulnerable. As the country heads into the next century, the uniquely American experience of financial impoverishment from nursing home costs will remain a threat to the long-term financial security of most Americans. Only the very wealthy and the very poor will be free of this worry. Middle-class Americans remain vulnerable. Uninsured nursing home costs unravel more lifetime financial plans than any other cause, including taxation and unwise investments.

7. RULES OF MEDICAID ELIGIBILITY

Most Americans who need long-term care not provided by family will end up on Medicaid. What are the rules of eligibility?

A. Asset Eligibility

1. Treatment of Assets. The Medicaid applicant must meet asset limits. If all funeral arrangements have been prepaid, the applicant may own no more than $2,000. If all funeral arrangements have not been prepaid, the applicant may retain an additional $1,500, for a total of $3,500, or she may purchase a pre-paid final arrangements plan.

2. Exempt Assets. One exception to these rules allows the single long-term care resident to own one home, with some upper limit on value varying by state. However, once the individual has been out of the home for six months, most states require the home to be sold. The sale proceeds must then be spent down to $3,500 or $2,000, depending on prepaid funeral arrangements. One car and household goods are also exempt.

3. Community Spouse Resource Allowance. The married long-term care resident is referred to as the "institutionalized spouse." Spousal Impoverishment rules allow the healthy spouse (referred to as the "community spouse") to retain the family home and one vehicle, regardless of value. In addition, the community spouse may retain a sum of assets known as the "Community Spouse Resource Allowance" (CSRA).

a. The amount is filled with exceptions and adjustments. Because Congress allowed each state to determine the absolute minimum amount the community spouse may retain without spend-down, in addition to the home and one car, the CSRA figure varies from state to state.

b. In Oregon, for 2016, the "floor" amount a community spouse may retain, in addition to the home and car, is $23,844. The maximum sum, or "ceiling", a community spouse may retain is $119,220. The calculation involves taking the total non-exempt assets and dividing that sum into halves. The CSRA is one-half subject to the floor and ceiling. Exceptions to these amounts are discussed below.

c. For example, a community spouse in Oregon owns a home, car and $30,000. She is allowed to retain the home, car and $23,844 of the $30,000.

d. For example, a community spouse in Oregon has $150,000 in investments. She is allowed to retain $75,000.

4. Exceptions to the Community Spouse Resource Allowance. Spousal Impoverishment provides for a number of exceptions to the standard CSRA.

a.Court Ordered Support. If a court order divides a couple's assets, the total value of assets awarded to the community spouse can supersede the minimum and maximum CSRA figures above. Because of a technicality called the 'income first' rule, this approach is available in a limited number of instances, such as when spouses vary in age and finance or if there is a prenuptial agreement. In Oregon, a court action known as a spousal support petition can increase the CSRA without a divorce or separation. Note that both divorce and separation may have very detrimental side effects. Loss of surviving spouse benefits, life insurance, health care coverage and Social Security benefits are among the negatives of divorce and separation. The emotional side effects of divorce range from difficult to catastrophic.

b.Agency Determination. Another exception to the CSRA is based upon low combined total income of the couple. If the couple's total income for 2012 is less than $1,898 per month, assets that would otherwise be spent down can be transferred to the community spouse to generate interest and other income to raise the community spouse's income. This computation is actually complicated because it turns on living expenses and where the institutionalized spouse is placed.

c.Other Options. Other strategies involve spending funds on exempt assets such as the house (or its mortgage), a car, etc., purchasing annuities which generate income for the community spouse, and more.

B. Medicaid Transfer Rule

1. Transfer or Gift Penalty. When assets are transferred out of the name of the single individual needing long-term care, or transferred out of the name of either the community spouse or the institutionalized spouse, a period of ineligibility for Medicaid is created. The period of ineligibility is determined by adding up the total value of all assets transferred during the 60 month "look-back" period immediately prior to making application for Medicaid. The period of ineligibility is determined by dividing the total value of assets transferred by $7,663 (in year

2015, projected to rise to $8,425 by Oct.1, 2016), supposedly the average cost of care in Oregon for one month. For example, if a couple transferred $50,000 within the 60 months prior to application, the period of ineligibility would last 6.52 months. However, the penalty does not start until the applicant has applied for Medicaid, been found ineligible exclusively because of the transfer, and is otherwise eligible on all other Medicaid criteria. This is an unbelievably severe approach to transfers.

2. Exempt Transfers. Some asset transfers are exempt from the waiting period. Note that the state of Oregon has created arguably over-broad rules to limit these transfers. The following are transfers that do not result in a period of ineligibility:

a. Transfer of the family home to:

- The community spouse.
- A minor, blind or disabled child of the single individual or married couple.
- A child of the individual who lived in the parent's home for two years while providing personal care to the parent preventing nursing home placement.
- A brother or sister of the single individual or married couple who lived in the home for one year and who has an equity interest in the home.

b. Transfer of any assets to:

- The community spouse.
- Someone other than the community spouse, where the assets transferred are for the sole benefit of the community spouse.
- The blind or permanently disabled child of the single individual or married couple.

C. Exempt Trusts

There are several trusts that are exempt for Medicaid eligibility.

1. Third Party Funded. If the trust is funded by a third party and is for special needs.

2. Self-Funded Trusts. If the trust is funded by the disabled person's assets, then there are two exempt trusts.

a.The first is the standard Special Needs Trust. It must be established before the beneficiary reaches age 65, must be established by a parent, grandparent, guardian or court, and must return funds to the State if any funds remain at the beneficiary's death.

b.The second is the Pooled Trust. It must be run by a non-profit, pool its funds, and must be for special needs. The law is in flux as to whether the beneficiary must be 65 or younger at funding or who receives the remaining proceeds.

D. Medicaid Income Rules

1.Applicant's Income. In most states, Medicaid's treatment of income only relates to the amount of the institutionalized spouse's income that the community spouse is allowed to keep. This is not true in Oregon. In Oregon and a few other states, the Medicaid applicant's income may disqualify if it exceeds $2,199 per month (for year 2015), *mostly* regardless of the source of the income. However, since October 1, 1993, creation of a unique form of living trust called an Income Cap Trust can remedy the problem of excess income, as discussed below. Each month, all of the applicant's income is deposited into the income trust. Although most of the monthly income is spent for care, the monthly deposit of the individual's income into the income trust solves the excess income problem. Any funds remaining in the income trust at the individual's death – usually a negligible amount – must be paid to the State, up to the amount of Medicaid assistance provided to the individual. This means that the family or other beneficiaries will receive nothing from the income trust.

2. Community Spouse's Income. In addition to the Community Spouse Resource Allowance (CSRA), Spousal Impoverishment established an allowance of income for the community spouse, known as the Community Spouse Monthly Maintenance Needs Allowance, abbreviated CSMMNA. This allowance does not apply to the single individual. The CSMMNA allows the community spouse to retain enough of the couple's combined income to raise the community spouse's income up to $2,981 in 2015.

a. Increases. The CSMMNA is increased if dependent children, parents, sisters or brothers live with the community spouse.

b. Separate Income. The community spouse's separate income, no matter how much, is never spent down on the institutionalized spouse's care

8. MEDICAID – NON-ELIGIBILITY ISSUES

A. Quality of Care. Is the quality of care paid by Medicaid the same as for care paid privately? Yes. Although this is a problem in some states, both Oregon and Washington have avoided it. The federal law prohibits this "Medicaid Discrimination" and, fortunately, the State and advocacy groups enforce it.

B. What Facilities Accept Medicaid? Do all facilities accept Medicaid? No. Medicaid is the "800 pound gorilla" because of its buying power. The result is that Medicaid's reimbursement rate to the facility is lower than private pay rate. One figure give is that the reimbursement rate averages 71 per cent of the private pay rate. Over 90 percent of nursing homes participate with Medicaid. A lower percent of foster homes and assisted living facilities participate and also get to pick on a patient-by-patient basis.

C. Does Medicaid Control Decisions?

Does the State control decisions about Medicaid recipient? Yes, but only about how the recipient's income is spent (excluding her personal allowance). The state does not actually manage the assets, if any, or any other part of the recipient's life.

D. What is Available for the Spouse or Dependents?

Does the rest of family receive moneys? As note in this outline, yes. There are provisions for spouses and dependents. As noted above, currently a spouse can have her total monthly income raised to $2,981 without much ado.

E. Does the Family Pay the Facility Extra?

It is important to note that if a member of your family qualifies for Medicaid, the provider cannot charge the family for the difference between the private pay rate and the Medicaid rate. To do so is a felony.

9. ELDER ABUSE – REPORTING REQUIREMENTS

As professionals we should be alert to the abuse of the elderly, defined as a person over 65 (and disabled as defined at ORS 124.005(8)).

A. Definitions. Elder Abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. It is defined in the statute at ORS 124.005 and is exceedingly broad. The following is a good summary of what is commonly seen[1].

1. Financial Abuse is the illegal taking, misuse, or concealing of funds, property, or assets of a vulnerable elder.

2. Physical Abuse is threatening or inflicting physical pain or injury on a vulnerable elder, or depriving them of a basic need.

3. Emotional Abuse is the infliction of mental or emotional anguish or distress on an elder person through verbal or nonverbal acts.

4. Sexual Abuse is the infliction of non-consensual sexual contact of any kind of a vulnerable elder.

5. Neglect is the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.

6. Abandonment is the desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.

---

[1] This definition is from www.oregoneverydayheroes.org. Note that it differs from the definition of elder abuse in the mandatory reporting statute at ORS 124.050, the cause of action for abuse at ORS 124.105 and ORS 124.110, and for a restraining order for elder abuse at ORS 124.005.

B. Mandatory Reporting**.** Oregon imposes a legal duty on certain "public or private officials" to report instances of elder abuse.[2] ORS 124.060. An elderly person is any person of 65 years or older. ORS 124.050(2).

1. Mandatory Reporters. There is a detailed list of the officials and it includes physicians, nurses, home health workers, DHS employees, certain therapists, counselors and public officials, and as of January 1, 2015, *attorneys*. ORS 124.050(9).

2. Attorney Exception. However, attorneys are not required to make a report by reason of information communicated to the attorney in the course of representing the client if disclosure of the information would be privileged under ORS 40.225 (a confidential communication subject to statutory exceptions) or detrimental to the client. ORS 124.060.

3. Abuse Which Must be Reported. The "abuse" that must be reported is defined in the statute at ORS 124.050(1):

> (1) "Abuse" means one or more of the following:
> (a) Any physical injury to an elderly person caused by other than accidental means, or which appears to be at variance with the explanation given of the injury.
> (b) Neglect.
> (c) Abandonment, including desertion or willful forsaking of an elderly person or the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person.
> (d) Willful infliction of physical pain or injury upon an elderly person.
> (e) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.465 or 163.467.
> (f) Verbal abuse.
> (g) Financial exploitation.
> (h) Sexual abuse.
> (i) Involuntary seclusion of an elderly person for the convenience of a caregiver or to discipline the person.
> (j) A wrongful use of a physical or chemical restraint of an elderly person, excluding an act of restraint prescribed by a physician licensed under ORS chapter 677 and any treatment activities that are consistent with an approved treatment plan or in connection with a court order.

4. Report. When a report is required, "an oral report shall be made immediately by telephone or otherwise to the local office of the Department of Human Services or to a law enforcement agency within the county where the person making the report is at the time of

[2] For an informational DHS website, see http://dhsforms.hr.state.or.us/Forms/Served/DE9022.pdf

contact." ORS 124.065(1). The identity of the reporter shall be kept confidential and good faith report made with reasonable grounds carries immunity from civil liability. ORS 124.075.

C. Protocol for Reporting. The following reporting protocol was suggested by Greg Moawad, formerly of the Multnomah County District Attorney's Office: (1) if there is an immediate safety/ danger issue, call 911, (2) if there is a potential for danger, but it's not certain, call the District Attorney's office and a visit can be arranged with a police officer (in Multnomah County, Greg Moawad, 503-988-3162), and (3) if there is no apparent immediate danger, call Adult Protective Services in your county or the state-wide hotline, 1-855-503-7233 (in Multnomah County, 503-988-3646).

D. Listen, Ask. Greg Moawad states that a person who becomes aware of abuse or neglect can help in the criminal prosecution of the abuser by trying to gather as much information as possible, by asking questions, by making notes of what they have learned, and by getting the names and numbers of other witnesses or players. Without witness testimony – and much of the above is admissible evidence in an elder abuse case – the criminal prosecution may flounder.

10. ELDER ABUSE – LEGAL TOOLBOX

Attorneys occasionally have clients whose family or circle involve instances of elder abuse. The attorney has many legal remedies at his/her disposal.

A. Guardianship. See above.

B. Emergency/Temporary Guardianship. See above. The statute requires an "immediate and serious danger to the life or health of the [person], and that the welfare of the [person] requires immediate action." ORS 125.600 (1).

C. Conservatorship. See above.

D. Emergency/Temporary Conservatorship. See above. There must be a finding that the person is "financially incapable…, that there is an immediate and serious danger to the estate of the [person], and that the welfare of the [person] requires immediate action." ORS 125.600(2).

E. Involuntary Civil Commitment. This is a court procedure in which two professionals or the county mental health officer, not the family or loved ones, initiate a process to involuntarily commits a person to a mental health facility because the individual is (a) a danger to his/herself or others, or (b) unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety, or (3) mentally ill, has been committed twice in three years and is exhibiting similar symptoms. ORS 426.005 *et seq*. There is a five day period, known as the "hold", during which treatment is given and at the end which an investigation occurs to determine the need for a hearing and further commitment. If the person is still dangerous after five days, there must be a hearing. If the result of the hearing is the need for continued commitment, then the state can hold the person for up to 6 months without further hearing.

F. Civil Action for Abuse of Elderly, Incapacitated or Disabled Person.[3] A person over 65, or an incapacitated or disabled person, or certain legal representatives, may bring a lawsuit for economic and non-economic damages, attorney's fees and costs, against a person who has committed physical abuse, financial abuse, or knowingly allowed it to occur. ORS 124.100 *et seq*. Physical abuse is detailed in the statute and includes assault, menacing, reckless endangerment, sexual abuse and physical or chemical restraints in certain situations. ORS 124.105. Financial abuse is the wrongful taking of money or property or the failure to return money or property. ORS 124.110.

G. Law Enforcement. The district attorney, Attorney General and law enforcement agencies may criminally prosecute for elder abuse as defined in the Elder Abuse statutes. ORS 124.125. Further, the district attorney may prosecute for criminal mistreatment if the victim is over 65. ORS 163.205. This is the intentional withholding of food, physical care or medical attention or causing physical injury, abandoning or neglect, or the taking of money or property.

H. Restraining Order. A person over 65 and certain disabled persons, or their legal representatives, may petition for a restraining order against an abuser if she has been the victim of

[3] In addition to the civil elder abuse remedies, an abuser is subject to other civil actions such as breach of contract, breach of fiduciary duty, interference with an inheritance, etc. I would like to thank Steve Owen, Fitzwater & Meyer for his helpful material on the elder abuse cause of action.

abuse in the last 180 days and there is an immediate and present danger of abuse from the abuser. ORS 124.010 *et seq*. A hearing shall be held on the petition and the court may order various remedies: that the abuser move from the residence, that the abuse and intimidation cease, that the abuser not enter premises and other remedies. ORS 124.020(1). The court can also order the return of money and property and related remedies. ORS 124.020(2). The court is to have a brochure explaining the procedure and forms for assistance. ORS 124.020(6).

I. Adult Protective Services. Oregon DHS has established the Adult Protective Services division to investigate abuse complaints of elderly and disabled persons. An investigation begins with the report of a situation at the local Area Agency on Aging[4] or 1-800-232-3020. Often 911 calls prompt the investigation.

J. Office of the Long Term Care Ombudsman. The Office of the Long-Term Care Ombudsman is an independent state agency that serves long-term care facility residents through complaint investigation, resolution and advocacy for improvement in resident care. Program staffing includes a State Long-Term Care Ombudsman, seven other full time staff members, and a statewide network of committed volunteers. To contact the office, call 1-800-522-2602.

K. Professional Fiduciaries. When there is no logical person to step in and address a potential elder abuse problem, one should consider a professional fiduciary. That is one of a group of persons who act as guardians, conservators, trustees, and in other roles, as a livelihood. (Generally, bank trust departments and trusts companies avoid contested manners.) For a list, see the Resources section at the end of this material.

11. PROBLEMS WITH THE ELDER ABUSE TOOLBOX

Notwithstanding the attorney's many available tools, other important issues bear on the successful resolution of an elder abuse situation. The ones below focus on the civil side. Obviously, cases are more difficult on the criminal side.

A. Capacity – No Litmus Test.

[4] Note that many aging services offices in Oregon use a different name. A web link to a directory is provided at the end of this material.

Individuals have a "right to folly." Attributed to Justice William O. Douglas

1. Problem. It is generally believed that a person has or does not have capacity; that capacity is black or white. In fact, we become aware that there are varying degrees of capacity or incapacity. However, the law only has the two options. If a person is competent, they can do the most foolish things and the law cannot stop them. If a person is incompetent, then their actions are reviewable and perhaps reversible.

The gray area between competency and incompetency is frequently when elder abuse takes place. The family member seeking to remedy the abuse is hindered by the fact that legal incapacity is unclear. This will create risk of failure if and when a protective proceeding, such as a guardianship or conservatorship is filed. This will also create a risk that the person is acting or filing a case when the supposed victim is competent, and acting foolish.

2. Example. A gentleman who received over $3,000 per month in tax free Veteran's disability income and each month for years gave away almost $2,000 per month to a number of millennial churches generally operating from store-fronts and P.O. boxes. The ministers were very attentive to the gentleman. Only some of the remaining $1,000 per month was contributed to the house causing the gentleman's wife and two children great financial hardship.

B. Going to Court .

"[W]here there is a legal right, there is also a legal remedy…" Blackstone, [an optimist] Commentaries

"Riiighttt…" Bill Cosby

1. Problem. To solve many elder abuse problems requires filing in court. The petition for a guardianship and/or conservatorship is perhaps the single most common approach. What should be noted that this requires paying lawyers, filing fees, maybe a bond, maybe a court visitor social worker report and more. If all goes well, the court will ordinarily allow the reimbursement of attorney's fees and all costs from the assets of the protected person. But sometimes the court will not allow that. And sometimes there are no assets.

2. Example. A gentleman was clearly being financially abused by his former wife and her two children. The gentleman had no children and his will left his estate to siblings in Sweden. A nephew tried to stop the abuse, eventually filing for guardianship and conservatorship. The gentleman, no doubt at the behest of his former wife, hired a lawyer to fight the proceeding. After the nephew had spent over $7,000 of his own funds on the lawyer, the nephew decided to give up the fight. He probably would have won in the end, been reimbursed for his fees, but it was not certain and the gentleman's attorney was assuring a prolonged fight.

C. Finding a Client.

"Somebody has to do something. (Hopefully not me.)" Potential Client

1. Problem. Many a problem requires a client to devote a good deal of time and emotional energy to its resolution. Often there is a willing family member. However, sometimes there is no one who has the wherewithal to take on the problem. There may be many reasons: the family lives far away, is not emotionally attached to the person or just does not have the desire.

2. Example. A gentleman lived alone and had a neighbor who was arguably taking financial advantage over the gentleman. The gentleman had no spouse or children but had two step children through his second wife. A stepdaughter was informed of the potential abuse by another neighbor and wanted somebody, but not her, to remedy the problem. The stepdaughter lived out of state, had no significant relationship with her step father (the marriage of her mother to him had been late in life) and was not certain, though did think, that she was a beneficiary of his modest estate.

D. The Victim Was Abusive

"What goes around comes around." Idiom

1. Problem. Elder abuse is often a feature in families where there is a history of other abuses. It may be that the elderly person that is being abused has a history of abusing others. It may be difficult to find willing persons to come to his aid.

2. Example. A gentleman with diminished capacity lived alone until some months earlier when his stepdaughter had offered to come and live with him. She was to help him as he aged. It turns out that she had a drug problem and not only ran through his savings but also managed to

get money on credit cards and from the equity in his house. It also turns out that the gentleman had sexually abused her when she was a child, which no one had ever reported to the authorities. The gentleman's two sons wanted to end the abuse, as they saw their inheritance slip away but were not interested in taking legal action against the stepdaughter (their stepsister).

E. The Abuser has no Funds

"You can't squeeze blood from a turnip." Idiom

1. Problem. It comes as no surprise that the abuser is frequently indigent. Even if they have embezzled, stolen, extorted, etc., the victim's money, the abuser is unlikely to save and invest it wisely. Hence, as it takes money to remedy the abuse and one is counting on a money judgment against the abuser as the remedy, there may be no solution.

2. Example. Son talked his mother into deeding her home to him and his wife. They would then borrow against it and build an addition in which the mother would live. This occurred but shortly thereafter the mother and the daughter in law discovered they could not live together and the son was not at all helpful. Mother asked for the house back. Son refused and mother sued. It turns out that the son had borrowed all possible equity in the house and used only some for the extension. The rest had gone to pay off past debts and loose living. The mother received only a small settlement.

F. The Client May be Disinherited

"Look out for Number One. If you don't, no one else will". Arnold Rothstein

1. Problem. A concerned family member may find themselves having to fight to stop abuse which is not perceived as abuse by the person with marginal capacity. If the concerned person is a beneficiary of the estate of the person being abused, there is the risk of disinheritance.

2. Example. A lady was befriended by a handyman. She was in her mid 70s and he was in his late 40s. He was living off of her and slowly using up her savings on the purchase of a truck, extravagant trips (that they both took) and unknown items. The daughters were very concerned and threatened a guardianship. It had to be explained to them that mother could have sufficient capacity to change her will, though she was being financially abused.

G. Conclusion. Ours is a society of laws and those laws work best when legal problems have identifiable and actionable legal solutions. Unfortunately, using the tools available to lawyers to remedy elder abuse has its own peculiar problems as set forth above. The attorney's perspective is that it is an imperfect system and one must proceed cautiously.

H. Resources.

1. A thorough national report on elder abuse by the National Association of Adult Protective Services Administrators can be found at http://www.elderabusecenter.org/pdf/research/apsreport030703.pdf

2. For elder abuse generally, see http://www.oregoneverydayheroes.org/ and http://www.elderabusecenter.org/default.cfm?p=faqs.cfm.

3. For addresses to Area Agency on Aging offices in Oregon, see http://www.oregon.gov/DHS/spwpd/offices.shtml

4. For more information on the Office of the Long Term Care Ombudsman for Oregon, see, http://www.oregon.gov/LTCO/index.shtml.

5. For information on professional fiduciaries, see the Guardianship/Conservatorship Association of Oregon at http://www.gcaoregon.org

Sam Friedenberg
Nay & Friedenberg